EXCHANGES IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

July 19, 2010

1. Exchanges - The Basics.

The PPACA provides that each state may establish, either through the vehicle of a governmental agency or a nonprofit entity, an **American Health Benefit Exchange** (Exchange) to facilitate the purchase of qualified health plans. While grants will be available to states for Exchange related planning activities, the law requires Exchanges to be self-sustaining by 2015:

> "The State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.[1]

An Exchange is also required to provide for the establishment of a **Small Business Health Options Program** to help small businesses (Fewer than 100 employees) enroll their employees in small group qualified health benefits plans. States are allowed to establish a single Exchange, incorporating assistance for both individual and small group purchasers. Starting in 2017, the states also can allow employers with more than 100 employees to participate.

a. Multi-State Exchanges. The law also allows for multi-state Exchanges whereby small states can band together creating larger pools of potential insureds than small states can produce from native populations.[2]

b. State Discretion. States have the discretion to refuse to implement an Exchange. However, refusal to establish an Exchange will result in the US Department of Health and Human Services establishing an Exchange within a state either directly under federal control or through a contract with a nonprofit entity.

States who choose to establish an Exchange will be required to demonstrate by January 1, 2013, that they will have an Exchange operational by January 1, 2014.

Starting in 2014, Exchanges will only be open to the following persons or groups:

- Self-employed and unemployed individuals
- Retirees not covered by Medicare
- Employees who work in businesses with no more than 100 employees or that do not provide insurance, and
- Small businesses.

It is important to note that by 2014 (or even earlier in some instances) there will be many new federal standards governing the behavior of carriers in both the individual and small group markets, even for those not participating in an Exchange. However, plans sold on an Exchange will be subject to additional requirements.

2. Planning Grants.

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[1] See PPACA Sec. 1311(d)(5)

[2] While not directly relevant to Iowa, It is interesting the law allows larger states to operate multiple Exchanges in separate geographic areas.

HHS will make planning grants available to states beginning in March 2011 to assist with the expenses incurred by states in setting up Exchanges. There is no statutory authority for these grants to continue past January 1, 2015.[3] (See Exhibit A) HHS will also provide technical assistance to states on facilitating participation of small employers in the SHOP program.

3. Requirements For Plans Sold on Exchanges.

a. **Qualified Plans/Essential Benefits.** The PPACA requires that all health insurance plans sold through an Exchange must be certified by the Exchange as "qualified health plans" (QHPs) providing coverage for "essential benefits."[4] The Act defines "essential benefits" as, at a minimum:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance-use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Insurers will face requirements allowing them to offer QHPs through an Exchange. The following are the basic requirements for carriers selling on an Exchange in 2014:

- Be "licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance...";
- Offer at least one QHP in the silver level and at least one plan in the gold level in an Exchange;
- "charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent"; and
- "complies with [other requirements described in greater detail below] and such other requirements as an applicable Exchange may establish."[5]

QHPs will have to meet the following minimum criteria to be certified by the HHS Secretary (per Sec. 1311 (c)(1)), though the law allows for the Secretary to develop additional standards):

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[3] See PPACA Sec. 1311(a)(4)(B).

[4] Along with "qualified health plans" Exchanges may sell stand-alone dental plans if they offer pediatric dental benefits meeting PPACA requirements and certain plans that provide catastrophic coverage along with limited primary care services.

[5] PPACA Sec. 1301(a)(1)(C).

- "meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs";
- "ensure a sufficient choice of providers ..., and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers";
- "include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically- underserved individuals";
- "Be accredited with respect to local performance on clinical quality measures...";
- Implement a quality improvement strategy that provides increased reimbursement or other incentives for the following, per §1311(c)(1):
  - ✓ Improvement of "health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage";
  - ✓ "implementation of activities to prevent hospital readmissions";
  - ✓ "implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, a health information technology under the plan or coverage";
  - ✓ "implementation of wellness and health promotion activities"; and
  - ✓ "implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings."
- Provide a uniform enrollment form (electronic or on paper) for use by individuals or employers obtaining or offering coverage through an Exchange;
- "utilize the standard format established for presenting health benefits plan options;
- "provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance ... ; and
- "report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act," which was established by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).[6]

Certain additional requirements will apply to PHPs sold exclusively through an Exchange (not all QHPs will be sold through the Exchange marketplace). The following requirements will have to be fleshed out by the HHS Secretary:

- A system for rating Exchange plans "in each benefits level on the basis of the relative quality and price."
- An "enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with [exchange plans] that had more than 500 enrollees in the previous year."
- Enrollment periods for Exchange plans—in particular, Exchange plans' initial enrollment period (i.e., the first time Exchange coverage is made available), the annual open enrollment period (after the initial enrollment period), specific special enrollment periods

[6] PPACA Sec.

(i.e., opportunities to enroll outside the annual open enrollment period because of particular circumstances),24 and special monthly enrollment periods for Indians Further defined in the Indian Health Care Improvement Act).

b. **Cost/Sharing/Deductibles.** Cost-sharing in a qualified plan is not allowed to exceed the cost-sharing for high-deductible health plans in 2014 (currently $5,950 individual/ $11,900 family). In later years, the limitation on cost-sharing will be indexed to the rate or average premium growth.

Deductibles for plans in the small group market are limited to $2,000 individual/$4,000 family, indexed to average premium growth. This amount may be increased by the maximum amount of reimbursement available to an employee under a flexible spending arrangement.

4. Plan Classifications.

Qualified plans are further classified into four groups based on the percentage of health care costs covered by the insurance carrier:

- **Bronze** – Coverage required to provide benefits that are actuarially equivalent to 60% of the full actuarial value of benefits under the plan.
- **Silver** – Coverage required to provide benefits that are actuarially equivalent to 70% of the full actuarial value of benefits under the plan.
- **Gold** – Coverage required to provide benefits that are actuarially equivalent to 80% of the full actuarial value of benefits under the plan.
- **Platinum** – Coverage required to provide benefits that are actuarially equivalent to 90% of the full actuarial value of benefits under the plan.

5. Additional Requirements.

a. Multi-State Plans. The PPACA also requires that each Exchange offer a minimum of two health plans that are available in two or more states. At least one of these multi-state plans must be administered by a nonprofit entity.

b. Medicaid and S-CHIP.

Individuals who apply for coverage through an Exchange who are found eligible for Medicaid or S-CHIP (hawk-i) coverage must be enrolled in Medicaid or S-CHIP. This so-called "screen and enroll" process does not apply to persons applying for coverage outside an Exchange. This means that, starting in 2014, Medicaid and S-CHIP eligible individuals will only be able to obtain individual (non-group) coverage outside an Exchange.[7] There are no guarantees that affordable coverage will be available to this group of Americans.

6. Exchange Limits.

The PPACA does not grant the states authority to set premiums for plans offered through Exchanges. While states can't set premiums for available on an Exchange, the PPACA does require that insurance companies justify any premium and cost share increases to state regulators. If regulators are not satisfied with the evidence presented to justify rate and cost-sharing increases, regulators have the power to exclude a company from participating in the Exchange**.**

Despite the limits on insurers, there is no provision in the law that either prohibits health insurers from offering insurance policies outside of the Exchanges or bars eligible individuals and employers from buying coverage outside the Exchange marketplace.

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[7] See PPACA Sec. §1311(d)(4)(F) for additional "screen and enroll" provisions.

Therefore, while the era of the individual insurance mandate will begin in 2014, no individual or employer will be forced to use the Exchange marketplace to buy coverage. This leaves open the question why either employers or individuals would chose to buy coverage through an Exchange. The choice of using an Exchange is positively conditioned on the powerful PPACA created incentives to participate in Exchanges.

7. Incentives to Use Exchanges

a. **Individuals and Families.** The PPACA provides two important incentives for individuals and families to buy health insurance through the Exchanges:

Premium Credits. Credits are available for lower income individuals and families with incomes up to 400% of the FPL who buy their coverage on an Exchange.[8] The credit is calculated on a sliding scale basis and will be paid directly to the insurance company selling the coverage, with the individual or family responsible for the remained of the premium.

Free Choice Vouchers. Employers who offer coverage to their employees, the PPACA requires the employer to provide a free-choice voucher to employees who qualify for premium credits and who spend between 8 and 9.8 percent of their income on premiums. These vouchers will equal what the employer would have paid to cover the qualifying employee under the employer's plan. These vouchers can be used if the employee makes the choice to not to enroll in the employer's existing coverage. In addition, free choice vouchers can only be used to enroll Exchange based plans. Employees who use the voucher are not eligible for the low-income premium credits.

8. Potential Impacts of PPACA Incentives.

a. Impact On Carriers. Policy makers have argued that the individual and employer incentives to participate in Exchanges will result in large pools of potential insureds who are potentially significantly attractive to insurance carriers, creating a desire among carriers to participate in the new Exchange marketplace.

b. Impact on Insurance Regulators. The strong presence of public funds (premium credits) within Exchanges may give state regulators an incentive to fight premium increases by using their ability to bar insurers from the Exchanges based on "unjustified" rate increases.

It is worth noting, that some industry commentators believe the Exchanges may not, at their initial stages of development, be able to achieve a critical mass of plans willing to participate in the Exchange marketplace. This is because insurers would be cautious about the composition of the pools that will be eligible to purchase coverage through an Exchange.

Another way to state this concern is that insurers may believe that adverse selection and other factors will result in pools that closely resemble existing state high risk pools, with healthy individuals buying outside the Exchanges. This would quickly lead to a death spiral situation for an Exchange.

However, the PPACA includes a number of provisions that can help Exchanges be successful. The fact that persons eligible to receive federal subsidies can only receive a subsidy (premium tax credit/cost sharing subsidy) if they purchase coverage through an Exchange is a significant

[8] In 2010, the income limit would be up to $43,420 for individuals and $88,200 for families.

factor in favor of Exchange success.[9] Also, Exchanges will take over some of the administrative duties and expenses normally handled by carriers, which should somewhat reduce carrier administrative costs.[10]

Exchanges will also take part, between 2014 and 2016, in a risk corridor program established by the HHS Secretary. This program is intended to protect insurers from large losses as Exchange coverage begins in 2014.[11]

The truth is that no one knows what the results will be in the initial stages of the roll out of Exchanges. The question that may be of interest, is what role state regulators can play and the Exchanges themselves can play in minimizing the risk of the so-called death spiral scenario.

9. State Actions.
While American Health Benefit Exchanges will not go into effect until January 1, 2014, the first insurance plans to operate on the Exchange will need to during 2013. We can also anticipate that state regulators will need to begin to collect information relating to premium increases starting in the 2010 plan year as they will need the data to determine if insurance carriers will be allowed to participate in Exchanges.

10. Exchanges - Key Deadlines.
See Exhibit A.

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[9] "For example, of the estimated 35 million individuals the Congressional Budget Office projects will be enrolled in nongroup coverage (including grandfathered coverage) in 2019, 24 million are anticipated to have that coverage through an exchange—of whom nearly 20 million will receive premium credits." See "PPACA Requirements for Offering Health Insurance Inside Versus Outside an Exchange" Congressional Research Service, (June 1, 2010) Available at http://www.nahu.org/legislative/resources/CRS_PPACA%20Requirements%20for%20Offering%20Health%20Ins%20Inside%20V%20Outside%20Exchanges_June%2010.pdf. See also: 1401(a): IRC Sec. 36B(c)(2)(A)(i), and PPACA Sec.1402(c)(4).

[10] For example, Exchanges will have to operate a toll-free telephone hotline to respond to requests for assistance; maintain a website where enrollees and prospective enrollees can shop for plans: enroll applicants in the plan of their choice, and work with other federal and state agencies regarding potential subsidies that would go to plans on behalf of eligible individuals. (See PPACA §1311(d)(4) for a list of required plan functions).

[11] "Risk corridors" are mechanism which adjust payments to plans according to a formula based on each plan's actual, allowed expenses as they relate to a targeted amount. If a plan's expenses are a certain percentage above the target, the plan's payment is increased, and vice versa. See also PPACA Sec. 1342.

Exhibit A

	Key PPACA Provision	State Role/Decision Date	Federal Deadline/Guidance
2011	**PLANNING GRANTS** Federal grants available for planning creation of a state-based Exchanges (Grants may be renewed if a state is making progress in starting an Exchange and in making market reforms. HHS will also provide technical assistance to states on facilitating participation of small employers in SHOP program.)	• Monitor federal grant and Exchange guidance/regulations	• Grant guidance available by **March 2011** • Regulation public release date TBD
2012/2013	**American Health Benefit Exchange** - State required to notify Federal government of Exchange participation decision by **Jan. 1, 2013.**	• Monitor/Perform PLANNING GRANT • State decide on Exchange participation • State to determine Exchange governance & structure (state government vs. non-profit) • Enact necessary statutory authorization for Exchange • Authorize necessary Exchange funding	• Notification by State before **Dec. 31, 2012** • State law/authorization must finalized
2014	• Exchange operational for individuals and small employers with 100 or fewer employees; • Subsidies available for eligible individuals and families with incomes between 133% FPL and 400% FPL	• Maintain oversight over Exchange operation.	Effective **Jan. 1, 2014**